Planned Parenthood®
Southeastern Pennsylvania

REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

DATE:______________________________ PATIENT #:________________________________

NAME OF PATIENT:____

DATE OF BIRTH:______________________ TELEPHONE #: ____________________________

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my health care visits.

I have been given information about the test(s), treatment(s), procedure(s), contraceptive method(s), to be provided, including the benefits, risks, possible problems/complications and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law. I understand that a new Pennsylvania law requires PPSP to give me written notification if a serious event compromising patient safety occurs under specific circumstances and that this notification will be sent to the mailing address listed on my contact sheet.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood Southeastern Pennsylvania's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby voluntarily request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, or HIV antibody test, if I request it).

I hereby acknowledge receipt of Planned Parenthood Southeastern Pennsylvania's Notice of Health Information Privacy Practices.

Signature of Patient ____

Date ____

I witness the fact that the patient received the above mentioned information and said s/he read and understood same and had the opportunity to ask questions.

Signature of Witness ____

Date ____

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Contact /Personal Information

Patient Number ______________________________ Today's Date ____________________

Name____ Nickname ____________________
First Last (optional)

Address__________________________/_______________________/________/________/
Street Apt# City State Zip

Is it O.K. for us to contact you by mail at above address? [ ]Yes [ ]No
If yes, can we use a Planned Parenthood envelope? [ ]Yes [ ]No
Address for mail, if different from the one above:

__________/__________________________/______________/______/______/
c/o Name Street Apt# City State Zip

Can we use a Planned Parenthood envelope at this address? [ ]Yes [ ]No

Your Telephone numbers
Phone 1 (______)______________________________(home) (work) (cell) Best time to call? _______
May we say "Planned Parenthood" to anyone who answers at this number? [ ] yes [ ] no; Code name:_________

Phone 2 (______)______________________________ (home) (work) (cell) Best time to call? ________
May we say "Planned Parenthood" to anyone who answers at this number? [ ] yes [ ] no; Code name: _____________

Marital status: [ ] Married [ ] Not Married

Social Security Number __ __ __ - __ __ - __ __ __ __ [ ] Female [ ] Male

Birth Date __ __ - __ __ - __ __ __ __ Age ________ **Staff Use Only:** ID Verified: [ ] yes [ ] no

Referred By: How were you referred to us?
[ ] Other Planned Parenthood Site [ ] Drove/walked by Center [ ] Family/Friend [ ] Internet
[ ] Newspaper Ad [ ] CHOICE Hotline [ ] Doctor [ ] Yellow Pages
[ ] Program done by PPSP [ ] School/College [ ] Other__________________________

Sometimes Planned Parenthood likes to contact patients for your suggestions or to give you information. May we:
[ ] Call to get your opinion over the telephone about your patient care experiences?
[ ] Send you information about Planned Parenthood from any of its departments in a Planned Parenthood envelope?
[ ] Please do not contact me for these purposes.

Who can we contact if unable to reach you or in case of emergency? (**This information is legally necessary**):

Name____
First Last

Address____
Bldg # Street Apt# City State Zip

Phone Number (_____)______________
Does this person know you are here [ ] Yes [ ] No Relationship________________
Should we (1) use a Planned Parenthood envelope or (2) plain envelope (circle the appropriate number)

Is it (1) OK to say Planned Parenthood to anyone who answers or (2) should we only use Planned Parenthood when speaking to the contact person? (Please circle appropriate number)

What is the name of your family doctor?

Patient Name____ Patient Number____________________

The information below is for statistical use only. No person will be excluded from services at Planned Parenthood Southeastern Pennsylvania based on duration of residency, citizenship, national origin, race, sexual orientation, marital status, religion, color, sex, method of referral, or contraceptive preference. With Census 2000, the Federal government introduced the option for choosing multiple races. Please choose from the lists below.

What county do you live in:

[ ] Chester County, PA [ ] Delaware County, PA [ ] Montgomery County, PA [ ] Philadelphia County, PA

[ ] Other Pennsylvania County ________________ (which county?) [ ] Other State_____________ (which state?)

Race/ Ethnicity

[ ] (04) Asian
[ ] (01) Black/African-American
[ ] (03) Native American/Alaskan Native
[ ] (07) Pacific Islander/Native Hawaiian
[ ] (02) White
[ ] (08) Asian + Black
[ ] (09) Asian + Native American/Alaskan Native
[ ] (10) Asian + Pacific Islander/Native Hawaiian
[ ] (11) Asian + White
[ ] (12) Black + Native American/Alaskan Native
[ ] (13) Black + Pacific Islander/Native Hawaiian
[ ] (14) Black + White
[ ] (15) Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (16) White + Native American/Alaskan Native
[ ] (17) White + Pacific Islander/Native Hawaiian
[ ] (18) Asian + Black + Native American/Alaskan Native
[ ] (19) Asian + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (20) Asian + White + Native American/Alaskan Native
[ ] (21) Asian + Black + Pacific Islander/Native Hawaiian
[ ] (22) Asian + Black + White
[ ] (23) Asian + White + Pacific Islander/Native Hawaiian
[ ] (24) Black + White + Native American/Alaskan Native
[ ] (25) Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (26) Black + White + Pacific Islander/Native Hawaiian
[ ] (27) White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (28) Asian + Black + White + Pacific Islander/Native Hawaiian
[ ] (29) Asian + Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (30) Asian + Black + White + Native American/Alaskan Native
[ ] (31) Asian + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (32) Black + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (33) Asian + Black+ White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (05) Other or Unknown

Are you of Hispanic origin? [ ] yes [ ] no

What is your primary language? (if not English)

[ ] Albanian
[ ] Arabic
[ ] Bosnian/Croation
[ ] Cambodian
[ ] Cantonese
[ ] Chinese
[ ] Creole
[ ] Ethiopian
[ ] French
[ ] Greek
[ ] Hindi
[ ] Ibo
[ ] Laotian
[ ] Mandarin
[ ] Polish
[ ] Portuguese
[ ] Russian
[ ] Spanish
[ ] Tagalog
[ ] Turkish
[ ] Ukranian
[ ] Urdu
[ ] Vietnamese
[ ] American Sign Language

[ ] Other_______________________ (which language?)

Are you a student: [ ] yes [ ] no

What is the highest grade you have completed (do not include the one you are in now)? ______
If you are in high school, middle school, junior high or elementary school, what is the name of your school?
____

Current Birth Control Method:

[ ] Birth Control Pills
[ ] Cervical Cap
[ ] Condom - female
[ ] Condom - male
[ ] Condom and Spermicide
[ ] Depo-Provera
[ ] Diaphragm
[ ] Implanon
[ ] IUD
[ ] Natural Family Planning / Fertility Awareness
[ ] NuvaRing
[ ] Patch (Ortho Evra)
[ ] Other
[ ] Spermicide
[ ] Sponge
[ ] Sterilization
[ ] None – pregnant
[ ] None – seeking pregnancy
[ ] None – not currently sexually active
[ ] None – not at risk of becoming pregnant
[ ] None – not interested or undecided

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MEDICAL HISTORY - GYN

Patient Name:________________________ **Age:**______ **Medical Record #:**______________ **Date:**______________

☐ **New Patient** ☐ **Established Patient**

SUBJECTIVE:

CHIEF COMPLAINT / Why are you here today? ☐ Routine GYN Exam ☐ Problem ☐ Other ______________________

How do you identify? ☐ Female ☐ FTM ☐ Other ______________

No Yes

☐ ☐ Are you receiving medical care with another health provider? Reason for visit(s) ______________________

☐ ☐ Are you allergic to any medications, metals, foods, anesthesia or other products? List: ______________________

☐ ☐ Are you currently taking any medications (including herbal remedies and vitamins)? List: ______________________

FAMILY HISTORY

No Yes

☐ ☐ I am adopted; my birth history is unknown.

☐ ☐ Did your mother take DES while she was pregnant with you? (if you were born before 1971)

Does your Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM) or Grandfather (GF) have any of the following?

No	Yes		Who	No	Yes		Who
☐	☐	High cholesterol	______________	☐	☐	Diabetes	______________
☐	☐	High blood pressure	______________	☐	☐	Breast disease	______________
☐	☐	Heart attack before age 50	______________	☐	☐	Cancer	______________
☐	☐	Stroke / Blood clots	______________	☐	☐	Genetic disorder(s)	______________

Circle: Father is living / deceased. Cause of death ______________ Mother is living / deceased. Cause of death ______________

PERSONAL HISTORY – Have **YOU** been diagnosed or treated for any of the following:

No Yes

1. ☐ ☐ Cancer
2. ☐ ☐ Genetic condition
3. ☐ ☐ High cholesterol / triglycerides
4. ☐ ☐ High blood pressure
5. ☐ ☐ Heart disease / Murmur / MVP
6. ☐ ☐ Stroke / Blood clots
7. ☐ ☐ Anemia
8. ☐ ☐ Blood clotting disorder
9. ☐ ☐ Sickle cell anemia / trait
10. ☐ ☐ Breast problems / Surgery
11. ☐ ☐ Asthma
12. ☐ ☐ Lung problems / Tuberculosis
13. ☐ ☐ Kidney / Bladder / Urinary Tract infection or problems
14. ☐ ☐ Recurrent vaginal infections
15. ☐ ☐ Pelvic infection / PID
16. ☐ ☐ Abnormal Pap smear
17. ☐ ☐ Cervical cryo, LEEP, Laser or Cone biopsy
18. ☐ ☐ Diabetes
19. ☐ ☐ Thyroid disease
20. ☐ ☐ Liver disease / Hepatitis / Mono
21. ☐ ☐ Gall bladder disease
22. ☐ ☐ Past surgery(s)
23. ☐ ☐ Past hospitalization(s)
24. ☐ ☐ Vaccination for Hepatitis B
25. ☐ ☐ Vaccination for Rubella / MMR

REVIEW OF SYSTEMS

No Yes

Constitutional:

26. ☐ ☐ Generally healthy

Cardiovascular:

27. ☐ ☐ Swelling / Fluid retention in hands or feet

REVIEW OF SYSTEMS – CONTINUED

No Yes

Hematological:

28. ☐ ☐ Easily bruised
29. ☐ ☐ Varicose veins

Neurological:

30. ☐ ☐ Headaches (frequent / severe) / Migraine
31. ☐ ☐ Numbness / Sensory loss
32. ☐ ☐ Seizures

Respiratory / Chest:

33. ☐ ☐ Breast lump / discharge
34. ☐ ☐ Shortness of breath

Eyes:

35. ☐ ☐ Blurred / Double vision (Not corrected by glasses or contacts)

Gastrointestinal:

36. ☐ ☐ Abdominal pain
37. ☐ ☐ Bowel pain / Constipation / Diarrhea
38. ☐ ☐ Rectal bleeding / Pain

Genitourinary:

39. ☐ ☐ Vaginal discharge, itching or burning
40. ☐ ☐ Frequency or burning with urination
41. ☐ ☐ Pelvic pain

ENT:

42. ☐ ☐ Ulcers / Sores in your mouth

Psychological:

43. ☐ ☐ Anxiety
44. ☐ ☐ Depression
45. ☐ ☐ Would you like a mental health referral today?

Skin:

46. ☐ ☐ Rash or itching

Patient Name:______________________ Age:_______ Medical Record #:________________ Date:__________________

HEALTH HABITS / SOCIAL HISTORY

No	Yes	
☐	☐	Douches
☐	☐	Self breast exams
☐	☐	Smokes: _______ cigarettes per day.
☐	☐	Alcohol intake: ________ drinks per week.
☐	☐	Drug use: daily / weekly / monthly. Type __________________
☐	☐	Alcohol and/or drugs cause problems in your life?
☐	☐	Others are concerned with your alcohol / drug habits?
☐	☐	Afraid of your partner(s) / others?
☐	☐	Parent(s) or guardian is aware of your visit today? (Only answer if under age 18.)

MENSTRUAL HISTORY

Age when period started: ________

Periods are: ☐ Regular ☐ Irregular ☐ Painful
Flow is: ☐ Light ☐ Moderate ☐ Heavy

Periods come every __________ days.

Bleeding lasts ___________ days.

When was the 1st **day** of your last period? ____________________

No	Yes	
☐	☐	Was your last period normal?
☐	☐	Do you think you might be pregnant?
☐	☐	Do you ever miss periods?
☐	☐	Do you ever have bleeding between periods?

SEXUAL HISTORY

Age at first intercourse: ______
# of sexual partners in last 30 days: ______
# of sexual partners in lifetime: ______
Partner(s) – Check all that apply: ☐ Male ☐ Female ☐ Transgender ☐ Intersex
Kind of sex: (please indicate all that apply:
☐ Vaginal (Giver / Receiver)
☐ Anal (Giver / Receiver) ☐ Oral (Giver / Receiver)
Do you have pain or bleeding with sex? ☐ No ☐ Yes
Have you ever been forced to have sex? ☐ No ☐ Yes
Have you ever exchanged sex for money or something else you wanted? ☐ No ☐ Yes
Do you consistently use condoms/dental dams for safer sex? ☐ No ☐ Yes
Do you plan children in the future? ☐ No ☐ Yes ☐ Undecided
Planning a pregnancy within the next year? ☐ No ☐ Yes ☐ Undecided

Have you ever had the following?

No	Yes		
☐	☐	Chlamydia	Date last treated: ____________________
☐	☐	Gonorrhea	Date last treated: ____________________
☐	☐	Herpes	Date last treated: ____________________
☐	☐	HPV/warts	Date last treated: ____________________
☐	☐	PID	Date last treated: ____________________
☐	☐	HIV	Date last treated: ____________________
☐	☐	Syphilis	Date last treated: ____________________
☐	☐	Trichomonas	Date last treated: ____________________
☐	☐	Currently experiencing itching, burning or unusual discharge?	
☐	☐	Did you douche, use a tampon, have bleeding or sex in the last 3 days?	

CONTRACEPTIVE HISTORY

Current method of birth control: ______________________________

How long have you used this method? ______________________________

What other methods of birth control have you used?

☐ Pills ________________	☐ Diaphragm	☐ Rhythm/Natural
☐ Depo Provera	☐ Cervical Cap	☐ Withdrawal
☐ Lunelle	☐ Male condoms	☐ Abstinence
☐ Evra Patch	☐ Female condoms	☐ Tubal sterilization
☐ Nuva Ring	☐ Spermacide	☐ Vasectomy
☐ IUD ________________	☐ Norplant	☐ Implanon

What method, if any, do you want today? ___________________________

PREGNANCY HISTORY

☐ Never Pregnant

Age at first pregnancy (at time of conception): _______

# of live births	_______	Date(s) _____________________
# of C-sections	_______	Date(s) _____________________
# of premature births	_______	Date(s) _____________________
# of miscarriages	_______	Date(s) _____________________
# of still births	_______	Date(s) _____________________
# of abortions	_______	Date(s) _____________________
# of ectopics	_______	Date(s) _____________________

I would like the following STI screening today:

☐ Chlamydia
☐ Gonorrhea
☐ HIV
☐ Syphilis

I would like information on the following:

	Given (Staff Initials)
☐ Birth Control Method(s) __________________	__________
☐ Emergency Hormonal Contraception	__________
☐ Preconception	__________
☐ Perimenopause	__________
☐ Smoking Cessation	__________

Patient Signature: ____ **Date:** ______________________

Comments:

☐ STI Risk Assessment done.
☐ Safer sex and condom use reviewed.
☐ ECP discussed / Fact Sheet N0051 given.
☐ HIV pretest counseling done.
☐ Other _______________________.
☐ Pt. urged to discuss visit with parent or guardian.

Interviewer Signature: ____ **Date:** ______________________

Clinician Signature: ____ **Date:** ______________________

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Additional History for Women 40 and Over

Patient Name:________________________________ Medical Record #:________________ Date:_____________

Family History

No	Yes	Unsure	
☐	☐	☐	Age mother and/or sisters went through menopause
☐	☐	☐	Osteoporosis

Personal History Have you ever had or do you have:

No	Yes	Unsure	
☐	☐	☐	Difficulty holding urine________________________
☐	☐	☐	Hot flashes________________________
☐	☐	☐	Night sweats________________________
☐	☐	☐	Depression/mood swings________________________
☐	☐	☐	Anxiety________________________
☐	☐	☐	Heart palpitations________________________
☐	☐	☐	Sleeplessness________________________
☐	☐	☐	Dryness of the vagina________________________
☐	☐	☐	Change in sexual desire________________________
☐	☐	☐	Pain or difficulty with urination________________________
☐	☐	☐	Change in bowel habits including bloody or tarry stools________________________
☐	☐	☐	Osteoporosis or broken bones after age 35________________________
☐	☐	☐	Mammogram: Date of last ______, result________________________
☐	☐	☐	Other problems________________________

Notes

Staff Signature:____